WORKERS' COMPENSATION
FIRST REPORT OF INJURY AND ILLNESS

Answer ALL questions. Sign, and give to your supervisor immediately. Please make and retain a copy for your records.

Section I: EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Telephone Number	Date of Birth	Age	Gender M F	Social Security Number	Average Weekly Salary

Address	City	State	Zip Code

Occupation/Title	Date of Hire	Work Status full-time part-time	Hours/day	Hours/week	Department

School Building / Location Accident Occurred (Street, City, Zip Code)	Immediate Supervisor

Section II: EMPLOYEE MEDICAL INFORMATION

Medical Treatment Received? Y N (*If no medical treatment, proceed to Section III)*

*****Should the injured employee receive medical treatment after the initial incident report, the employee can contact PMA at 1-888-476-2669.*

Any Lost Time Y N	If yes, date disability began	If out of work: will salary be continued

Name of Attending Physician	Inpatient Hospitalization
Address of Attending Physician	Name of Hospital

City	State	Zip Code	City	State	Zip Code

Section III: INCIDENT INFORMATION (*Please complete the entire section)*

Date of Injury or Illness: (Month/Day/Year)	Time of Injury/ Illness	AM PM

Is This a Recurrence of a Previous Injury or Illness Yes No
If "Yes" Please Give Details (i.e., date of previous Injury and provide details)
Describe Part (s) of Body Injured/Nature of Occupational Illness (i.e., left arm, right foot, head, multiple, etc.)
Nature of Injury / Illness (i.e., laceration, burns, fracture, strain, etc.)
Cause of Injury / Illness (motor vehicle, machine, strain, or injury by lifting, etc.)
Injury/Occupational Illness Description
If Employee Unavailable for Signature, Explain Circumstances in this Space and Enter Incident

OVER →

WORKERS' COMPENSATION
FIRST REPORT OF INJURY AND ILLNESS

Employee Signature ____________________ Date ____________________

SECTION IV: WITNESS(ES)

Yes No

Name (please print) ____________________ Phone # ____________________

Name (please print) ____________________ Phone # ____________________

SECTION V: SUPERVISOR INFORMATION

Date Supervisor Notified: (Month/Day/Year)	Time Supervisor Notified: AM PM	

Principal/Supervisor Name (please print) ____________________

Principal/Supervisor Signature ____________________ Date ____________________

BY SIGNING THIS FORM, YOU ARE AFFIRMING THAT ALL INFORMATION PROVIDED BY YOU IS TRUE. PLEASE NOTE THAT KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH AN APPLICATION FOR WORKERS' COMPENSATION OR DISABILITY BENEFITS IS A CRIME. ANY PERSON KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH THIS APPLICATION MAY BE SUBJECT TO CRIMINAL PROSECUTION THAT COULD RESULT IN FINES AND/OR IMPRISONMENT.